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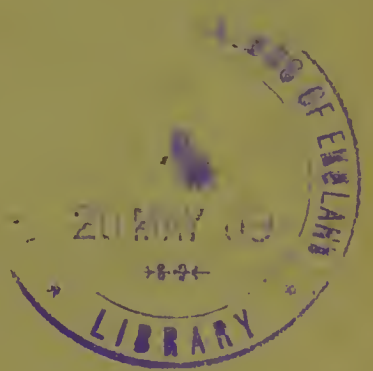

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CASES OF APPENDICITIS WHICH DO NOT DEMAND OPERATION.

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IT is a fact that, most of the literature of appendicitis is from the pens of the surgeons; and most of the cases of appendicitis are treated in the hands of the physicians. The vast majority of cases of appendicitis recover, and never figure in the statistics of this much discussed subject. Unfortunately for the education of the surgeon most of the appendicitis which he sees demands operation, and many of the patients should have been operated upon before he saw them, yet all of these represent a minority of the cases. Basing the contention upon their own experiences, many competent surgeons declare that all cases should be operated upon. This would be good doctrine were it modified with the proviso, that, it should mean, all cases which are sent to the competent surgeon should be operated upon by them. But to promulgate the teaching that every case of appendicitis should be operated upon by somebody is dangerous surgery and poor medicine.

In these discussions the surgeon is prone to look at the subject from his own personal viewpoint, and not from that of the average status of surgery. Moreover, it has seemed to me that we all give too little heed to the dangers and disadvantages *per se* of abdominal operations; and while we are familiar with the surgical operative treatment of appendicitis, are we as well posted as we should be upon the internal treatment of this disease and its possibilities, and is it not true that we develop the habit of operating upon cases because of the assumption that they are sent to us for the purpose of operation? I have long since ceased to regard appendicitis as a distinctly surgical disease, and am well convinced that every case from the beginning should be under both surgical and medical observation. There should be both confidence in the internal treatment, and the knowledge that surgery can suplement its deficiencies.

No rule can be laid down as a guide by which to determine just when a case shall be operated upon, but there are certain general principles which may be formulated to aid in determining which cases shall have operation and which shall not; and it is desirable to discover the middle ground upon which opinions differ in this matter. My own experience has involved many cases which I have dismissed cured without operation, and many cases which have perished for want of earlier operation. To have operated upon all of these patients at the beginning of their attack would have given a much lower mortality, but still better than this, in my judgment, would have been to have operated only upon those of the second class at the opportune time when operation was indicated. I am satisfied with the cases which recovered without operation. They sometimes return to me, or someone else operates upon them in a subsequent attack, but this does not militate against the first judgment. The surgeon who operates upon all patients would have no better fortune with the second class of patients. As to the first class, I believe that so large a proportion have no serious recurrence, that, excepting in the special instances which I shall mention, operation is not called for.

Operation, I should say, is indiced in the following cases:

1. *Appendicular abscess; that* is, appendicitis causing a circumscribed collection of pus, constituting a tumor.

2. *Appendicitis giving rise to an inflammatory mass,* which can be determined as a distinct tumor, and accompanied by the evidences of suppuration and cellulitis. That is the condition in which the omentum usually constitutes the main bulk of the tumor, being adherent or wrapped about the appendix, thickened and infiltrated with inflammatory products, and adherent on the other side to intestine or abdominal wall.

3. *Appendicitis with great enlargement of the appendix by pus distension* (empyema of the appendix). These cases are usually of slow development.

4. *Fulminating appendicitis:* the cases which are severe from the onset, showing rapid pulse; high temperature; and a high and increasing multinuclear leucocyte count, indicative of severe infection or meagre resistance.

5. *Gangrenous appendicitis, and perforating appendicitis.* These two are often sequelæ of the above type, and demand immediate operation.

6. *Appendicitis, while giving rise to none of the above conditions, does not begin to subside,* if severe after the first or second day; or, if mild, after the fourth or fifth day, as shown by persistent elevation of temperature, increase of pulse rate, pain, tenderness, and increased polynuclear index.

7. *Appendicitis* falling in any of the above classes, which has persisted and extended its infection to neighboring structures.

8. *Diffuse Peritonitis*—either from perforation without adhesions, or with multiple foci of suppuration. Operation should be done in these cases unless the state of the patient is so bad as to contraindicate operation.

9. *Symptoms of intestinal obstructure,* either after operation or in the course of the disease, demand operation.

10. *Sudden or gradual exacerbations of symptoms,* occurring during the progress or subsidence of attack, however mild, call for operation.

11. *Appendicitis with evidences of metastatic infection* in other parts or organs.

12. Operation is indicated *after a second attack,* if more severe than the first; and always after repeatedly recurring attacks, unless there is a mitigation of severity in each succeeding one.

13. *After the subsidence of acute appendicitis, if there persist the symptoms of chronic disturbance,* referable to the appendix, such as pain, tenderness, digestive and intestinal unbalance(due to continuous infection of a low grade, chronic congestion, distension, or adhesions), the appendix should be removed.

14. If the patient is to live in some place remote from competent surgical assistance, operation is indicated after a second attack of appendicitis. Operation may properly be done in such a case after or during a first attack.

15. When the physician and surgeon are in doubt as to the advisability of operation, operation should be done.

Notwithstanding, this is a large catalog of indications for operation; as a matter of fact it represents but a small proportion of the cases of appendicitis. Most of the cases lie outside of this category.

The cases in which operation is not indicated are the primary attacks of appendicitis, not falling under any of the above heads, of slight or moderate severity, in which the symptoms do not grow worse after the first 36 or 48 hours, and which show an amelioration by the second or third day. These are the typical cases, the commonest type of appendicitis, beginning with difuse colicy pains about the mid-abdomen, nausea, often vomiting, pain and tenderness after a few hours localizing at the appendix, rigidity of the overlying muscles, rise

of temperature, increase of pulse rate, leucocytosis 12,000 to 16,000, polyneuclear leucocytes 75 per cent. to 85 per cent (with a low percentage comparative to the total leucocytosis according to Gibson's standard chart). Many variations of these characteristics occur; and the severity of all the symptoms may be so mild as to render diagnosis doubtful or so severe as to place the case at once in the operative class. These cases pathologically belong to classes of (1) acute appendicular obstruction, with swelling of the mucous membrane, or foreign body, or stricture occlusion, having colic as a prominent symptom; (2) acute catarrhal appendicitis; (3) acute catarrhal and interstitial appendicitis; (4) acute interstitial appendicitis with congestion, but not infection, of the peritoneal coat; (5) exacerbations of chronic appendicitis with a low grade of infection.

Appendicitis of the acute catarrhal and interstitial type without thrombosis of the nutrient vessels are the commonest types of the disease. Under judicious management according to the most recently accepted plans, most of them go on to recovery. It is estimated that 75 per cent. of all cases of appendicitis recover without operation I believe that the percentage is higher than this. Everyone of these mild cases should be watched carefully; if this cannot be done, immediate operation in the hands of a competent surgeon is indicated. Opportune operation is preferable to taking chances with an emergency which may not be properly met.

The remarkable statistics, which have developed out of Ochsner's method of treatment, now make indefensible the belief that every case of appendicitis should be operated upon, if such a belief ever were defensible.

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